BOARD OF COMMUNITY HEALTH
July 14, 2005

The Board of Community Health held its regularly scheduled meeting in the Floyd Room, 20th Floor, West Tower, Twin Towers Building, 200 Piedmont Avenue, Atlanta, Georgia. Board members attending were Jeff Anderson, Chairman; Richard Holmes, Vice Chairman; Chris Stroud, M.D. (Secretary); Inman English, M.D.; Ann McKee Parker, Ph.D.; Mary Covington; Ross Mason; Kim Gay, and Mark Oshnock. Commissioner Tim Burgess was also present. (A List of Attendees and Agenda are attached hereto and made official parts of these Minutes as Attachments # 1 and # 2).

Mr. Anderson called the meeting to order at 12:06 p.m. The Board unanimously approved the June 9 meeting minutes with the correction to insert Ms. Covington's name in Paragraph 9, Sentence 5.

Mr. Anderson began his opening comments by reminding the board of the huge challenge before them—future budgets. He said towards new business at the end of the meeting, the board will probably discuss moving next month's meeting later in the month to invite certain providers and stakeholder groups to discuss informally and formally where we've been and where we need to go from a fiscal standpoint.

Mr. Anderson called on Commissioner Burgess to make his report. Mr. Burgess began by informing the Board that the Department will start providing board members with media packets that will include coverage related to different issues and topics the Department follows. He mentioned one article that was recently published about Upper Payment Limit (UPL) that he says that may have caused misunderstandings about the Department's fiscal status. He said Carie Summers, CFO, reported to the Board last month DCH finally negotiated with CMS the ability to get a full year's worth of claiming for FY 05, which for DCH was about $300 million, and it is part of the agreement to put forward a new UPL plan to be more consistent with the rules CMS now wants DCH to abide by. It will have a big effect on the state's ability to earn UPL which means the $300 million earned and gained in FY 05, the Department will no longer be able to get those kinds of monies for Medicaid in FY 06 going forward. Commissioner Burgess said the Department built the FY 06 budget on a minimum level of these UPL earnings, expecting to earn enough in FY 05 to carry forward in FY 06 and balance the FY 06 budget with excess earnings from FY 05. This has been a plan for over a year now about how DCH transitions itself. He said this article gave the impression that DCH was losing $300 million in federal funding. Commissioner Burgess said that's not true; the $300 million loss in UPL has nothing to do with the other budget reductions that will be discussed later in the meeting.

The second item Commissioner Burgess mentioned was the PeachCare Dental Program. On June 21, Margie Preston, Director of Professional Services, convened a meeting of about 14 people, including DCH staff, representatives from the Georgia Dental Association, Georgia Dental Society, Georgia Dental Coalition, various independent dentists and advocates. The charge of the committee was to look at all the different codes in the dental program to see if there were codes that could be eliminated to allow other codes to be added in a budget-neutral fashion. The group did not produce a recommendation that could be brought back to the Board today, but it did highlight some suggestions and possibilities of how DCH might restructure those codes.

Commissioner Burgess said the CMO procurement is on track to have contracts signed and winners announced very soon, maybe as early as next week.

Commissioner Burgess said the CON Commission had its first meeting on June 27. Dr. Daniel Rahn is the chair; Mr. Anderson and the Commissioner both serve on the Committee. The next meeting will be held August 8.

Finally, Commissioner Burgess reported on the C-PORT Trial. Twenty-five hospitals have applied for participation in the Trial. The Department is working on the mechanics of determining which of those hospitals will be a part of the trial. He said he would keep the board updated as that process moves along. After addressing questions from the Board, the Commissioner concluded his report.

Mr. Anderson asked Mark Oshnock, Chairman of the Audit Committee to give the Committee's report. Mr. Oshnock reported on three items: 1. Audit Charter - the Committee agreed and passed on the Audit Charter to the full board to review and vote

on it at the next meeting; 2. Status of FY 2004 financial audit - the audit is nearly completed. The single audit had eight findings that are disclosed as part of the single audit; and 3. FY 05 Audit – books were closed June 30, 2005, and the first draft financial statements will be prepared by mid-August for an audit process that will start in September and wrap up in December.

Mr. Anderson called on Dr. Chris Stroud, chairman of the Care Management Committee to make the Committee's report. Dr. Stroud reported that the Care Management Committee met briefly and the CMO announcements are expected to be made next week. The enrollment broker announcements are expected to be made next week as well. The disease management contract negotiations are in the final phases and announcements will be made within the next one to three weeks. He said Kim Gay gave a report on the SOURCE program she visited in the Blue Ridge area.

Mr. Anderson called on John Upchurch, Director, State Health Benefit Plan. Mr. Upchurch began with updating the board on the surcharges added this plan year. For the July 1 plan year, a $40 per month surcharge was added for tobacco users and $30 per month surcharge for those employees who had spouses covered by the plan but could have gotten coverage through their employer. There are about 54,000 employees who are paying the tobacco surcharge for an annual revenue of $25.9 million and on the spousal surcharge about 26, 648 employees for an additional $9.6 million in revenue--a total of about $35.5 million. There are about 12,000 members who did not answer the surcharge questions during open enrollment. Those members will be given another opportunity to answer those questions, so it is possible they may have those surcharges waived once they respond and that would reduce the revenue by $7.4 million, which would still be substantially higher than the budgeted amount of $16.5 million.

Mr. Upchurch began discussion on the dependent eligibility verification project. The SHBP required all members with family coverage to submit written documentation on their covered dependents. This had never been done before and the process began on a sample basis, auditing about 700-800 contracts a month from December 2003 to January 2005. In February 2005 the SHBP did a complete audit on every remaining member. In total, since February, the SHBP sent 167,000 audit letters to those employees who cover their dependents and requested documentation on 341,000 dependents. About 310,000 dependents have been verified, 26,000 have not respond at all (there coverage has been suspended until the documentation has been received), and 4,319 who were dropped during open enrollment. Mr. Upchurch said the estimated savings on the dependents that have been dropped totally had medical expenses in excess of $38 million. Conservatively, the department thinks the number will be around $30 million. The budgeted savings were $16 million. Mr. Upchurch talked about the cost of the audit. He said bids from outside firms to perform the dependent audit were from $2-6 million and over a period of six months to two years. Due to the price and length of time, SHBP performed the audit in-house utilizing overtime and temporary labor. The final cost was $177,000. Commissioner Burgess said the audit was well worth the effort and commended the staff on their hard work. Mr. Upchurch concluded his report after he and Commissioner Burgess addressed questions from the board. (A copy of the State Health Benefit Plan Dependent Verification Project is hereto attached and made an official part of these Minutes as Attachment # 3).

Mr. Anderson called on Carie Summers to present the UPL Payment Public Notice. She said the Department is required to do this public notice as part of the negotiations with CMS related to the UPL claiming in FY 05. This public notice supports the State Plan Amendment that DCH formally communicates to CMS changes in financing. The Department is asking for this change to be effective for dates of service on or after July 1, 2005. Mr. Holmes MADE A MOTION to APPROVE the UPL Payments Public Notice. Dr. Parker SECONDED THE MOTION. Mr. Anderson called for votes; votes were taken. The MOTION WAS UNANIMOUSLY APPROVED. (A copy of the Upper Payment Limit Payments Public Notice is attached hereto and made an official part of the Minutes as Attachment # 4).

Mr. Anderson called on Neal Childers, General Counsel, to review the Estate Recovery Amendments. He said the estate recovery program in Medicaid initially was a voluntary optional program on behalf of the states. Congress authorized it but did not require it in 1982. In the Omnibus Budget Reconciliation Act (OBRA) of 1993, Congress changed the authority to a requirement and mandated that all states operating Medicaid programs have an estate recovery program in order to recover some of the sums expended as medical assistance benefits. The General Assembly enacted legislation in compliance with that in 1997 to authorize the Department to implement the program. The Department's regulations were initially proposed and adopted by the Board over a year ago pending approval by CMS of the state plan amendment. CMS recently notified the Department that the state plan amendment had been approved subject to changes in one specific part of the rules, 111-3-8-.07. Mr. Childers summarized the changes: paragraph 5, a reference to the controlling authority is modified to reference the federal regulation rather than the state regulation that no longer contains the relevant timeframes; and in paragraph 9 former subparagraph (d) is deleted and grammatical revisions are made to the remaining subparagraphs. Dr. Parker MADE THE MOTION to approve the Estate Recovery Amendments to be published for public comment. Ms. Covington SECONDED THE MOTION. Mr. Anderson called for votes; votes were taken. THE MOTION WAS UNANIMOUSLY APPROVED. (A copy of the Estate Recovery amendments is attached hereto and made an official part of the Minutes as Attachment # 5).

Mr. Anderson called on Carie Summers to discuss the FY 06 and FY 07 Budgets primarily as it relates to Medicaid benefits. Ms. Summers reviewed five topics: historical expenditures, cost drivers, future needs, Governor's budget instructions and discussion of options.

She began with a brief background of the historical expenditures to give the board a sense of trend in the benefits. Ms. Summers gave the board an overview of total expenditures for the Medicaid program starting with FY 2000 to FY 2005. There are four cost drivers: enrollment, price, utilization, and scope of services. Enrollment drivers are micro/macro economics, population, disease state or condition, legislative and regulatory mandates, and marketing, outreach and awareness. The price drivers are free market (pharmacy), medical inflation, patient acuity levels, and reimbursement policies. Utilization drivers are no medical home, limited knowledge on accessing the healthcare system appropriately, access to care, and acuity level of patient. Ms. Summers said expenditures can be impacted by the scope of services covered. Sixty-one percent of the services Medicaid covers are actually for mandatory services. The top optional services are pharmacy, children's dental, children's intervention services, dialysis and hospice. A fifth area impacting how the department spends money and how much is spent is administrative controls and the way the plan is managed such as cost avoidance via third party liability, population management, claims administration, eligibility determination and certificate of need.

Ms. Summers continued with the FY 07 Budget. She said the Department is expecting an increase in FY 07, and 64% of that increase is driven by enrollment, utilization and price growth. Ms. Summers said the Department estimates it will need a little under $2.4 billion (state funds) in FY 07. For FY 07 OPB asked agencies to submit two scenarios—a budget that is equal to 98% of our FY 06 appropriations and a budget proposal that is equal to 104% of the FY 06 appropriations (4% growth). Ms. Summers continued the discussion with needs versus limits. She said the Governor's instructions say the most an agency can request is 4% growth over FY 06. That is a $269 million state fund differential between maintaining current Medicaid benefit growth and the maximum allowed. The minimum limit is a 2% reduction and that differential is $388 million. She said the Department recently sent to provider groups a solicitation for ideas and information from them about how to handle a scenario of budget reductions of around $200 million. The Department is hopeful that it can have additional discussions with OPB to see if some of this growth would be exempted so the Department would not have almost $400 million in cuts.

Finally, Ms. Summers talked about what are some of the options to reduce expenses: managed care savings, enrollment controls, utilization, price, change in scope

of service and other administrative efficiencies. She said these are some of the parameters the Board could use to begin having discussion about areas for further exploration. Ms. Summers concluded her overview. (A copy of the Fiscal Year 2006 & 2007 Medicaid Benefits Presentation is attached hereto and made an official part of the Minutes as Attachment # 6).

Mr. Anderson said the board will be following up with the letters from various stakeholders. The Board will have a more formalized process. Mr. Oshnock will chair and be the liaison between the board and development of the budget. Mr. Anderson stated that a lot of the stakeholders should be in the same room at the same time as we discuss ideas as how they affect each other. He said the Board will try this year to have a more open process as the budget is developed and will arrange a meeting to seek stakeholders' input.

Mr. Anderson opened the meeting for public comment. Mr. Phil Socoloff gave public comment.

Mr. Anderson asked the board to consider canceling the August 11 and meet on August 25, the second scheduled meeting in the month of August. Mr. Mason MADE THE MOTION to approve canceling the August 11 and meeting on August 25. Dr. Stroud SECONDED THE MOTION. Mr. Anderson called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED.

There being no further business to be brought before the Board at the meeting Mr. Anderson adjourned the meeting at 1:32 p.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE _____ DAY OF _____, 2005.

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MR. JEFF ANDERSON
Chairman

ATTEST TO:

_____
CHRISTOPHER BYRON STROUD, M.D.
Secretary

Official Attachments:

#1 List of attendees
#2 Agenda
#3 SHBP Dependent Verification Project
#4 Upper Payment Limit Payments Public Notice
#5 Estate Recovery Amendments
#6 FY 2006 & 2007 Medicaid Benefits Presentation